

# Sexual Abuse in Later Life

by Holly Ramsey-Klawnsnik, Ph.D. and Bonnie Brandl, MSW

During the past 30 years, our society has made considerable strides in recognizing and responding to sexual victimization. Attention to older adults as potential victims, however, has lagged behind the recognition of younger adults, children, and adolescents as age groups requiring protection from sexual abuse. Vierthaler (2008) discussed why elders have been overlooked as targets of sexual assault and underserved as victims. She argued: "Rape myths have left elders out of the image of victims of sexual violence and without an appropriate community response when they are victimized. Thus, while elder sexual assault victims may require more assistance and specialized help due to age-related disabilities and other factors, they often receive fewer services and interventions than younger victims (Vierthaler, 2008, p. 307)."

To raise awareness and provide guidance for professionals, this article addresses sexual assault in later life and specifically focuses on victimization of elders that occurs in the context of intimate partner violence, incest, and care facilities. While stranger and acquaintance assaults against elders also occur, the forms discussed in this article tend to come to the attention of authorities more frequently. Professional experience also suggests that older individuals are at higher risk of sexual assault in their relationships, families, and care facilities than for victimization perpetrated by a stranger or casual acquaintance. To illustrate, Eckert and Sugar (2008) evaluated 2,399 women who presented to an emergency department for sexual assault and found that older women were more likely than younger women to be assaulted in their own homes or in care facilities.

## Prevalence, Incidence, and Dynamics

In 1998, Lachs et al. reported that there were no reliable estimates of the incidence

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or prevalence of elder sexual abuse in the community or in facilities. In the years since that publication, incidence and prevalence studies of elder sexual abuse have unfortunately not been undertaken. While the frequency with which older individuals are sexually assaulted is unknown, research and clinical findings demonstrate that elders are not only at risk of sexual victimization, but also at risk of severe physical and psychosocial harm from this abuse. For example, Poulos and Sheridan (2008) reviewed seven research studies that examined genital injuries in women after sexual assault and concluded that post-menopausal women are more likely to sustain genital injuries than younger women. Similarly, Eckert and Sugar (2008) documented that genital trauma is more common in women over the age of 55 than in younger women who are sexually assaulted.

Burgess, Ramsey-Klawnsnik and Gregorian (2008) studied 284 sexual assault victims ranging from age 60 to 100. Among these victims, the behavior that was displayed following the abuse demonstrated that they experienced psychosocial trauma regardless of whether or not they could verbally discuss the event(s). Furthermore, there was no significant difference between elders with and without dementia in post-abuse distress symptoms. The authors concluded by noting that statistics on elder sexual abuse are not tracked in criminal justice reporting and recommended expanding the national database to include details regarding intentional sexual injury of elders.

Sexual violence towards older adults can involve a range of offenses including "hands-on" behaviors such as rape and molestation, "hands-off" behaviors such as voyeurism, exhibitionism, sexual threats or unwanted comments, and "harmful genital practices." The last category includes painful, intrusive, or unnecessary procedures that are committed during the provision of personal care to individuals requiring assistance. For example, this could involve inserting fingers or other objects into the vagina of an elder while bathing her. Perpetrators often thinly disguise these behaviors as personal care; however, when invasive practices are not prescribed in a nursing care plan they are typically sexually motivated,

potentially dangerous, and experienced by victims as abusive. This form of elder sexual abuse is discussed in Chihowski and Hughes (2008) and Ramsey-Klawnsnik (2003) among other works.

Beyond these conclusions regarding the prevalence, incidence, and dynamics of sexual abuse of elders, the rest of the article addresses the issues specifically related to (1) sexual abuse by intimate partners, (2) incestuous abuse, and (3) sexual assault in care facilities. Each section includes an illustrative case. The article then concludes with a list of tips to provide guidance for practitioners who might find themselves faced with a potential incident of elder sexual victimization.

## Sexual Abuse by Intimate Partners

A qualitative analysis of 130 cases of alleged elder sexual abuse investigated by state abuse authorities (Ramsey-Klawnsnik, 2003) revealed 100 cases of suspected sexual abuse within the family. These included situations of intimate partner violence and incest. Intimate partnerships can include dating, and short- or long-term relationships, including marriages. Some partners/spouses may have been together for 50 or more years. In other cases, the relationship is new—often due to the death of or divorce from a previous partner. Domestic violence occurs in some of these relationships.

Sexual abuse can be used to control and humiliate domestic violence victims and to inculcate feelings of shame, embarrassment, hopelessness, powerlessness, and isolation. Facilitators of support groups for older abused women report that many older women who have been abused for 40 or more years have experienced sexual abuse throughout that relationship.

*Illustrative Case: "Sixty-year-old Mrs. V. has been married for forty-one years, and is the mother of six children. She is diagnosed with clinical depression, onset during menopause. Her son sought assistance for her due to marital rape. During the PS (Protective Service) investigation, Mrs. V. acknowledged that throughout her marriage she had been repeatedly hit*

and forcibly sexually assaulted by her husband. There was also an extensive history of Mr. V. physically abusing the children. Although Mrs. V. had not been hit in many years, her husband continued to dominate her. She was distraught about the continuing marital rape. Among the tactics used by Mr. V. to control his wife were prohibiting her from driving, working outside of the home, or managing money” (excerpted from Ramsey-Klawnsnik, 2003, p. 46).

For other older victims, sexually abusive behavior is a new occurrence in the relationship. In some older adults, dementia or another physical or mental health condition leads to the onset of sexually inappropriate and/or aggressive behavior. In these cases, victims experience trauma and possibly physical harm. These victims can benefit from sexual assault services. Interventions for the older perpetrator may need to include the health care and mental health systems. It is important to note that cases of late onset of sexual victimization in an otherwise non-violent long-term relationship are rarely seen in comparison to long-term domestic violence situations.

### Incestuous Abuse

The Ramsey-Klawnsnik analysis (2003) documented that incestuous elder abuse involved adult offspring and grandchildren as well as other relatives as perpetrators. Many of the older incest victims whose cases were studied experienced strong mixed emotions toward their abusers that complicated their trauma responses and made it difficult for them to accept intervention. Seeking and accepting help was especially difficult for parent victims who feared that their abusive children would face criminal charges and other negative consequences. The incest victims in this study often relied upon their abusers for care and assistance and conversely, many of the abusers were dependent upon their victims for necessities such as housing. Chihowski and Hughes (2008) pointed out that perpetrators often exercise a high level of power and control and abuse their elderly victims emotionally, physically, and financially in addition to sexually. This coercive control greatly interferes with an older victim’s capacity to reach out for assistance and to take steps to self-protect. The following case illustrates problems often experienced by older individuals who are sexually abused by family members.

**Illustrative Case:** *Mrs. Evelyn W. is an eighty-four year old widow with a serious problem with her son, Lester. Lester, age 53, has always had difficulty coping with life. For years, he has periodically lived with Evelyn. She finds his drinking and depression hard to tolerate. He does bizarre things—like the strange sexualized drawings with which he covered the walls of his bedroom. When drunk, hung-over, or angry, he walks around Evelyn’s apartment naked, masturbates in her presence, and makes sexually offensive and threatening comments. He is chronically unemployed and therefore she supports him on her limited fixed income, causing her stress and sacrifice. She fears that he will become homeless or incarcerated. These fears, along with her embarrassment and maternal instinct to protect her offspring, prevent her from discussing with others the problems he creates or taking steps to put him out of her apartment.*

Professionals attempting to assist victims like Evelyn need to understand the complex and ambivalent trauma reactions typically experienced by older incest victims and the web of forces that inhibit them from self-protecting and seeking help. Chihowski and Hughes (2008) addressed these issues, as well as the challenges that often confront professionals involved in family elder sexual abuse cases.

### Sexual Assault in Care Facilities

Ramsey-Klawnsnik, Teaster, Mendi-ondo, Marcum, and Abner (2008) reported on their multi-state study of 429 sexual assault cases that occurred in care facilities which included 124 suspected victims ages 60 to 101. Disabilities experienced by many of these older alleged victims included dementia and major psychiatric illness, and rendered fewer than half to be able to communicate without difficulty. This and other factors prohibited state abuse investigators and facility regulators from gathering sufficient evidence in all cases to make informed decisions as to whether or not to substantiate sexual abuse allegations. Only 27% of the elder abuse cases were substantiated, involving 33 victims and 32 identified sexual assailants. The vast majority (83%) of

the alleged perpetrators were facility staff and residents.

A significant finding was that while most of the alleged perpetrators were staff members, only 4% of them were confirmed as perpetrators. The second largest group of alleged perpetrators was facility residents, 52% of whom were confirmed as such. An overwhelming majority of both the alleged and confirmed perpetrators were male, although three females were also confirmed sexual perpetrators against elderly individuals requiring facility care. The confirmed victims had a mean age of 82 and 18% were male.

Particularly troubling was the fact that none of the confirmed assailants were arrested, despite the presence of sufficient evidence (including victim disclosures, witnesses, and medical findings) to enable state authorities to substantiate these 33 cases of elder sexual assault within care facilities. The authors concluded that it is critical that law enforcement become involved in investigations of alleged cases of sexual assault in facilities, and urged increased collaboration between civil and criminal investigators.

Of course, there are a number of complex issues inherent in facility sexual abuse. The problems faced by potential and actual victims are first and foremost. Individuals who require facility care typically experience serious illnesses, disabilities, and limitations in functioning, rendering them at risk for all types of victimization, including sexual assault. Risk is particularly high for those unable to independently complete personal care tasks, as illustrated by the following case (also excerpted from Ramsey-Klawnsnik et al, 2008):

**Illustrative Case:** *“A male direct care provider employed in a nursing home was accused of digitally penetrating a resident. The female resident had suffered a stroke and was incontinent, yet mentally competent and able to communicate clearly. The resident reported to the facility management, a relative, and the investigator that the aide, who was not assigned to provide care to her, entered her room and forcefully inserted his fingers into her vagina causing her pain and soreness along with significant emotional distress. The investigator concluded that the resident was able to clearly articulate her experience of the event and was emotionally traumatized by it” (p. 370).*

A related problem faced by victims is that frequently people with disabilities are not believed when they disclose that they have been sexually assaulted in their care facilities. For example, the aide accused of digitally penetrating the woman in the illustrative case above denied that he had committed a sexual assault, claiming that he had only placed his fingers into her undergarment to determine if she had urinated and needed to be changed. State abuse authorities did not substantiate the woman's disclosure, despite the fact that facility records proved that the aide was not assigned on the day of the incident to work on the unit housing the alleged victim. As a result, the alleged perpetrator not only avoided criminal charges, he was allowed to keep his job caring for residents of the nursing home.

### Challenges for Facility Management and Staff

In addition to the problems faced by victims who are elderly or disabled, there are a number of challenges for the staff and administrators of care facilities. To illustrate, Ramsey-Klawnsnik et al. (2007) discussed the complex responsibilities of facility management and staff to prevent and respond appropriately to the sexual abuse of residents. Duties include screening, hiring, training, and supervising employees with due regard for the vulnerability of residents to abuse perpetrated by staff and a recognition of the potential for sexual assault. When fulfilling these duties, steps must be taken to minimize the likelihood that sexual abusers will be employed and that abuse of residents could occur or go unnoticed.

Similarly, screening, accepting, and supervising residents must be accomplished in ways that minimize the potential for resident perpetrated sexual and other abuse. Important responsibilities include training all staff to recognize the signs and symptoms of sexual abuse and to respond ethically, swiftly, and compassionately to potential or actual sexual assault of residents. Appropriate responses include protecting possible victims from continuing sexual abuse or intimidation; seeking immediate, independent, qualified medical care and forensic examinations for alleged victims; filing legally required reports with civil and criminal officials and cooperating with abuse investigations; protecting the privacy of victims and the integrity of evidence; and notifying court-appointed guardians

of residents who are either alleged victims or perpetrators.

### Challenges Faced by Investigators

These cases also pose considerable challenges for investigators. Some were revealed in a study of sexual abuse that was conducted with vulnerable adults residing in care facilities. Specifically, Adult Protective Services (APS) personnel were queried on problems they encounter when investigating allegations of sexual assault against residents (Ramsey-Klawnsnik and Teaster, 2008). Among difficulties cited were the lack of 24-hour availability of investigators, the fact that sexual assaults are rarely witnessed, and the failure of many facilities to obtain sexual assault exams for alleged victims in a timely fashion. Investigators also stated that they are often blocked from interviewing alleged perpetrators due to multiple factors and that the frequent delayed reporting of alleged incidents causes evidence to deteriorate. They also reported that facility staff members sometimes engage in suggestive questioning or intimidation of alleged victims prior to an independent investigative interview by abuse authorities. Communication barriers experienced by alleged victims due to disabilities and the fact that sexual abuse is often difficult to prove add further complications. The APS investigators also expressed frustration with facilities that fail to promptly call in law enforcement officials when allegations arise.

### Tips for Practitioners

Practitioners who deal with older adults might be faced with a case of suspected sexual victimization. Most importantly, do not hesitate to ask potential older victims about possible sexual assault or abuse. Do not assume that because a person is older, sexual abuse could not have occurred. On the other hand, refrain from attempting to investigate alleged elder sexual abuse unless you are a trained investigator and have the authority to investigate. Well-intended but untrained professionals often contaminate critical evidence of sexual assault when they attempt to conduct an investigation.

**Screening.** All professionals serving older adults need to be able to *screen* for potential sexual abuse by asking open-ended and relevant questions when signs or symptoms present. When responses to open-ended questions (such as, "Have you

been hurt?") indicate that sexual abuse has likely occurred, practitioners are advised to consider the following:

- Follow-up on coded disclosures. Some victims may wear many layers of clothing, talk about not wanting someone near them, say things like "he's my boyfriend" (referring to a young staff person) or wonder if they could be pregnant. They may not directly talk about sexual abuse.
- Keep in mind that if the older victim has a relationship with the perpetrator, he or she may be more interested in maintaining the relationship or protecting the offender than assisting with a criminal justice investigation. Some older victims focus more on services for the offender than for themselves.
- Recognize that older adults may have difficulty talking about sexuality and sexual abuse. Some may be uncomfortable using sexual language or words for body parts.
- Some older victims may have difficulty talking to younger professionals who are similar in age to their grandchildren or great-grandchildren. Sexual assault agencies should consider hiring older staff and volunteers to be available to work with these victims.
- Special care and techniques are required when older alleged sexual abuse victims experience either communication barriers or limitations in mental capacity. It is therefore critical to avoid the assumption that an older person with either of these conditions cannot provide meaningful information about assault experienced. Guidelines for interviewing possible victims with communication barriers (such as aphasia, dementia, and developmental disabilities) are provided in Ramsey-Klawnsnik and Klawnsnik, 2004.
- Realize that victims may be fearful of the consequences if they cooperate with criminal or civil sexual abuse investigations. Protect the privacy and safety of all possible victims.
- Avoid contaminating possible evidence of sexual assault. Do not destroy sheets, clothing and other possible physical evidence. Do not clean up the victim or the scene. Carefully, quickly, and factually document all evidence of sexual abuse that has come to your attention.

- Focus on the victim's immediate needs and well-being. This will likely include encouraging the victim to get a medical examination and follow-up health care. It may be necessary to arrange for a qualified and independent forensic examination (such as those provided by Sexual Assault Nurse Examiners) without delay.
- Offer the services of a sexual assault advocate to the older victim to work on trauma issues and to provide information and referrals.

#### Report Elder Abuse to Authorities.

- Know state laws about your reporting responsibilities. Law enforcement, Adult Protective Services, or facility licensing authorities may conduct elder sexual abuse investigations. If you are a mandated reporter, be aware of any restrictions you may have for contacting authorities, especially due to confidentiality and privileged communication laws and standards. Mandatory reporting responsibilities listed by state can be found at <http://www.abanet.org/aging/docs/MandatoryReportingProvisionsChart.pdf>. Mandatory reporting requirements can also be found by contacting the state administrator of the APS program. When in doubt about your reporting responsibilities and/or restrictions, it is best to obtain legal advice.
- File all legally required and mandated reports of alleged elder abuse without delay to trigger a formal abuse investigation. In most states, professionals (health care, elder care, and

social services personnel as well as criminal justice representatives, etc.) are legally required to report to state authorities all alleged abuse of older adults as well as younger adults with disabilities.

- When you must report suspected elder sexual abuse, if possible, explain to the older adult that you are reporting because you care about that individual's safety and are required by law to do so. In some cases a report and investigation can increase the risk of danger. Therefore, it is critical to consider safety precautions and develop a safety plan with the older victim.

Too often elder sexual abuse is not recognized or addressed. Older victims may feel terrified, ashamed, embarrassed or blame themselves. These feelings can be exacerbated by unhelpful or uninformed professional response. Many older victims are not aware of existing services and sources of assistance. Some have physical and/or cognitive limitations that make it difficult or impossible to report sexual abuse. As the population ages, practitioners will see increasing numbers of cases of elder sexual abuse. Interventions must include a victim-centered approach focusing on immediate safety needs and long-term trauma issues. In most cases, collaboration with multiple agencies may also be required.

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